SERFF Tracking Number:	*SEFL-126646812*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46120*
Company Tracking Number:	*IND APPS 2010 - HEALTH*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*IND APPS 2010 - Health*		
Project Name/Number:	*IND APPS 2010 - Health/IND APPS 2010 - Health*		

Filing at a Glance

Company: Assurity Life Insurance Company

Product Name: IND APPS 2010 - Health	SERFF Tr Num: SEFL-126646812	State: Arkansas
TOI: H21 Health - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 46120
Sub-TOI: H21.000 Health - Other	Co Tr Num: IND APPS 2010 - HEALTH	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Kristi Hendrickson	Disposition Date: 07/08/2010
	Date Submitted: 07/02/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: IND APPS 2010 - Health
Project Number: IND APPS 2010 - Health
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 07/08/2010

Deemer Date:
Submitted By: Kristi Hendrickson
PPACA: Not PPACA-Related
Filing Description:

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 06/22/2010
Domicile Status Comments: Approved
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 07/08/2010
Created By: Kristi Hendrickson
Corresponding Filing Tracking Number:

Form No. Form Title
47-350-05051 (R05-10) Application for Insurance
47-351-05051 (R05-10) Trust Information/Additional Beneficiary
47-352-05051 (R05-10) General Section
47-354-05051 (R05-10) Physician Information and Agreement
47-362-05051 (R05-10) Field Underwriter’s Statement
75-315-02201 Guaranteed Insurability Insurance Application

SERFF Tracking Number:	*SEFL-126646812*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46120*
Company Tracking Number:	*IND APPS 2010 - HEALTH*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*IND APPS 2010 - Health*		
Project Name/Number:	*IND APPS 2010 - Health/IND APPS 2010 - Health*		

75-803-02255 Temporary Conditional Insurance Agreement
75-819-05055 Tobacco Use Questionnaire

Form Replacement
Form No. Replaced Form No. Approval Date Filing No.
47-350-05051 (R05-10) 47-350-05051 12/06/2006 SEFL-125052422
47-351-05051 (R05-10) 47-351-05051 12/06/2006 SEFL-125052422
47-352-05051 (R05-10) 47-352-05051 12/06/2006 SEFL-125052422
47-354-05051 (R05-10) 47-354-05051 12/06/2006 SEFL-125052422
47-362-05051 (R05-10) 47-362-05051 12/06/2006 SEFL-125052422
75-803-02255 LU-CR (06/05) 08/25/2005 unknown
75-819-05055 A-DI/A 34 08/02/2001 unknown

Form Utilization and Main Changes
47-350-05051 (R05-10), Application for Insurance – This page is utilized to record the personal information of the proposed insured, policyowner, beneficiaries, and proposed joint-insured, if any. This page also records the premium payment mode and payor information if the payor is different than the policyowner or proposed insured. The main changes are asking for the amount of tobacco used per day and the Premium Payment section.

47-351-05051 (R05-10), Trust Information/Additional Beneficiary – This page is to be utilized if the owner and/or beneficiary is a trust or if additional room is needed to list beneficiaries for the policy. The main change is in the layout of the form.

47-352-05051 (R05-10), General Section – This page is utilized to record the answers to the general questions. The main changes are in the replacement questions (9a & 9b) and the addition of question 10.

47-354-05051 (R05-10), Physician Information and Agreement – This page is utilized to record the primary physician's information and all necessary signatures. The main change is in the Physician Information section.

47-362-05051 (R05-10), Field Underwriter's Statement – This page provides additional underwriting information to the Company from the licensed broker/agent. The main changes are questions 3 – 8 and asking for the other insured's proposed underwriting class for term, whole and universal life.

75-315-02201, Guaranteed Insurability Insurance Application – This page is utilized when applying for additional disability income insurance as provided by a guaranteed insurability rider. The main difference to this form is to make it look and appear like the other Assurity forms.

75-803-02255, Temporary Conditional Insurance Agreement – This form is used when a premium payment is included

with an application for health coverage. The main change to this form is making it specific to lines of business and adding the health questions.

75-819-05055, Tobacco Use Questionnaire – This page is utilized when applying for non-tobacco rates on an in-force policy that was issued at tobacco rates. The main difference to this form is to make it look and appear like the other Assurity forms.

Marketing
These forms will be used by licensed agents and brokers who sell Assurity products.

Company and Contact

Filing Contact Information

Kristi Hendrickson, Policy Filing Specialist
1526 K Street
Lincoln, NE 68508

policyfiling@assurity.com
402-437-3452 [Phone]
402-437-3802 [FAX]

Filing Company Information

Assurity Life Insurance Company
1526 K Street
P.O. Box 82533
Lincoln, NE 68501-2533
(800) 276-7619 ext. [Phone]

CoCode: 71439
Group Code: -99
Group Name:
FEIN Number: 38-1843471

State of Domicile: Nebraska
Company Type: Life/Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$400.00
Retaliatory?	No
Fee Explanation:	50.00 per form
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Assurity Life Insurance Company	$400.00	07/02/2010	37721831

SERFF Tracking Number:	*SEFL-126646812*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46120*
Company Tracking Number:	*IND APPS 2010 - HEALTH*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*IND APPS 2010 - Health*		
Project Name/Number:	*IND APPS 2010 - Health/IND APPS 2010 - Health*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/08/2010	07/08/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	07/06/2010	07/06/2010	Kristi Hendrickson	07/06/2010	07/06/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Temporary Conditional Insurance Agreement	Kristi Hendrickson	07/02/2010	07/02/2010

SERFF Tracking Number:	*SEFL-126646812*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46120*
Company Tracking Number:	*IND APPS 2010 - HEALTH*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*IND APPS 2010 - Health*		
Project Name/Number:	*IND APPS 2010 - Health/IND APPS 2010 - Health*		

Disposition

Disposition Date: 07/08/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SEFL-126646812*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46120*
Company Tracking Number:	*IND APPS 2010 - HEALTH*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*IND APPS 2010 - Health*		
Project Name/Number:	*IND APPS 2010 - Health/IND APPS 2010 - Health*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Application for Insurance	Approved-Closed	Yes
Form	Trust Information/Additional Beneficiary	Approved-Closed	Yes
Form	General Section	Approved-Closed	Yes
Form	Physician Information and Agreement	Approved-Closed	Yes
Form	Field Underwriter's Statement	Approved-Closed	Yes
Form	Guaranteed insurability Insurance Application	Approved-Closed	Yes
Form *(revised)*	Temporary Conditional Insurance Agreement	Approved-Closed	Yes
Form	Tobacco Use Questionnaire	Approved-Closed	Yes
Form	Temporary Conditional Insurance Agreement	Replaced	Yes

SERFF Tracking Number:	*SEFL-126646812*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46120*
Company Tracking Number:	*IND APPS 2010 - HEALTH*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*IND APPS 2010 - Health*		
Project Name/Number:	*IND APPS 2010 - Health/IND APPS 2010 - Health*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/06/2010
Submitted Date	07/06/2010
Respond By Date	

Dear Kristi Hendrickson,

This will acknowledge receipt of the captioned filing.

Objection 1

- Application for Insurance, 47-350-05051 (R05-10) (Form)

Comment:

All applications must contain a Fraud Statement as outlined under ACA 23-66-503 and Bulletin 7-97.

Objection 2

- Physician Information and Agreement, 47-354-05051 (R05-10) (Form)

Comment:

Will this part of the application be used with all of the attached application/enrollment forms. If any of the forms submitted are a stand alone form and it does not contain a Fraud Statement, that statement must be added to the form.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number:	*SEFL-126646812*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46120*
Company Tracking Number:	*IND APPS 2010 - HEALTH*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*IND APPS 2010 - Health*		
Project Name/Number:	*IND APPS 2010 - Health/IND APPS 2010 - Health*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/06/2010
Submitted Date	07/06/2010

Dear Rosalind Minor,

Comments:
Thank you for your correspondence.

Response 1

Comments: These forms are always packaged together to include the 47-354-05051 (R05-10) which contains the required fraud statement. If in question please reference the filing SEFL-125052422 under which these forms were previously approved.

Related Objection 1

Applies To:

- Application for Insurance, 47-350-05051 (R05-10) (Form)

Comment:

All applications must contain a Fraud Statement as outlined under ACA 23-66-503 and Bulletin 7-97.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments: These forms are always packaged together to include the 47-354-05051 (R05-10) which contains the required fraud statement. None of the forms are stand alone forms they are packaged together to make an application.

Related Objection 1

Applies To:

SERFF Tracking Number:	*SEFL-126646812*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46120*
Company Tracking Number:	*IND APPS 2010 - HEALTH*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*IND APPS 2010 - Health*		
Project Name/Number:	*IND APPS 2010 - Health/IND APPS 2010 - Health*		

- Physician Information and Agreement, 47-354-05051 (R05-10) (Form)

Comment:

Will this part of the application be used with all of the attached application/enrollment forms. If any of the forms submitted are a stand alone form and it does not contain a Fraud Statement, that statement must be added to the form.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for your time and consideration.

Sincerely,
Kristi Hendrickson

SERFF Tracking Number:	*SEFL-126646812*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46120*
Company Tracking Number:	*IND APPS 2010 - HEALTH*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*IND APPS 2010 - Health*		
Project Name/Number:	*IND APPS 2010 - Health/IND APPS 2010 - Health*		

Amendment Letter

Submitted Date: 07/02/2010

Comments:

A form number on the form schedule has been corrected.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
75-803-02255	Application/Enrollment Form	Temporary Conditional Insurance Agreement	Initial				50.800	75-803-02255 Health 05-10.pdf

SERFF Tracking Number:	*SEFL-126646812*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46120*
Company Tracking Number:	*IND APPS 2010 - HEALTH*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*IND APPS 2010 - Health*		
Project Name/Number:	*IND APPS 2010 - Health/IND APPS 2010 - Health*		

Form Schedule

Lead Form Number: 47-350-05051 (R05-10)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/08/2010	47-350-05051 (R05-10)	Application/Enrollment Form	Application for Insurance	Revised	Replaced Form #: 47-350-05051 Previous Filing #: SEFL-125052422	55.600	47-350-05051_R05-10_.pdf
Approved-Closed 07/08/2010	47-351-05051 (R05-10)	Application/Enrollment Form	Trust Information/Additional Beneficiary	Revised	Replaced Form #: 47-351-05051 Previous Filing #: SEFL-125052422	64.400	47-351-05051_R05-10_.pdf
Approved-Closed 07/08/2010	47-352-05051 (R05-10)	Application/Enrollment Form	General Section	Revised	Replaced Form #: 47-352-05051 Previous Filing #: SEFL-125052422	50.000	47-352-05051_R05-10_.pdf
Approved-Closed 07/08/2010	47-354-05051 (R05-10)	Application/Enrollment Form	Physician Information and Agreement	Revised	Replaced Form #: 47-354-05051 Previous Filing #: SEFL-125052422	50.300	47-354-05051_R05-10_.pdf
Approved-Closed 07/08/2010	47-362-05051 (R05-10)	Application/Enrollment Form	Field Underwriter's Statement	Revised	Replaced Form #: 47-362-05051 Previous Filing #: SEFL-125052422	57.300	47-362-05051_R05-10_.pdf
Approved-Closed 07/08/2010	75-315-02201	Application/Enrollment Form	Guaranteed insurability Insurance Application	Initial		46.500	75-315 _R06-10__06-29.pdf
Approved-Closed 07/08/2010	75-803-02255	Application/Enrollment Form	Temporary Conditional Insurance Agreement	Initial		50.800	75-803-02255 Health 05-10.pdf
Approved-Closed 07/08/2010	75-819-05055	Application/Enrollment Form	Tobacco Use Questionnaire	Initial		65.900	75-819-05055.pdf

ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (800) 276-7619 • FAX (877) 864-6630

Application for INSURANCE

PLEASE PRINT IN BLUE OR BLACK INK

1. PROPOSED INSURED

Legal Name (*First, Middle, Last*) | Date of Birth (*MM/DD/YYYY*) / /

Social Security No. | ☐ Male ☐ Female | E-mail | Age

Home Address (*Street Address, City, State, ZIP+4*)

Personal Phone No. ( ) | Birth State/Country | Height ft. in. | Weight lbs.

Has the Proposed Insured ever used any form of tobacco or nicotine-based products, or substitutes such as patches or gum? ..... ☐ Yes ☐ No

If YES, please list type: amount per day: last date of use (*MM/DD/YYYY*) / /

Is the Proposed Insured a United States citizen, or does the Proposed Insured have permanent resident *(green card)* status? ..... ☐ Yes ☐ No

If the Proposed Insured has permanent resident status, please list permanent resident *(green card)* number.

Does the Proposed Insured have a valid driver's license? ☐ Yes ☐ No If YES, please list state of issue and number.

Is the Proposed Insured currently working at least 30 hours per week in primary occupation? ☐ Yes ☐ No Length of employment (*Years Months*) /

Primary Employer | Employer's Address (*Street Address, City, State, ZIP+4*)

Full-time Employment (*Occupation, Duties*) | Part-time Employment (*Occupation, Duties*)

Gross monthly income $ | If self-employed, net monthly income $

2. POLICYOWNER *(Policyowner is the Proposed Insured unless otherwise indicated)*

If Ownership is a trust, complete the Trust Information/Additional Beneficiary form rather than this section.

Legal Name (*First, Middle, Last*) | Date of Birth (*MM/DD/YYYY*) / /

Social Security No. | Relationship to Insured | Birth State/Country

Home Address (*Street Address, City, State, ZIP+4*) | E-mail

Contingent Owner's Name (*First, Middle, Last*) | Contingent Owner's Relationship to Insured

3. BENEFICIARIES *(Do not complete if applying for Reversionary Annuity coverage)*

If Beneficiary is a trust, or if additional space is needed, complete the Trust Information/Additional Beneficiary form.

Primary Beneficiary Name *(First, Middle, Last)*	Relationship	Soc. Sec. No.	Date of Birth	Share %
			/ /	
			/ /	
Contingent Beneficiary Name *(First, Middle, Last)*	**Relationship**	**Soc. Sec. No.**	**Date of Birth**	**Share %**
			/ /	
			/ /	

4. PREMIUM PAYMENT

Please indicate preference for payment type and billing frequency below:

Type

☐ Direct Billing ☐ Automatic Credit Card
☐ List Billing *(employer)* ☐ Automatic Bank Withdrawal

Frequency

☐ Annual ☐ Semi-Annual ☐ Quarterly
☐ Monthly *(not available with Direct Billing)*

Payor Name (*First, Middle, Last*) | Billing Address (*Street Address, City, State, ZIP+4*)

Secondary Payor Info. (*First, Middle, Last*) | Billing Address (*Street Address, City, State, ZIP+4*)

TRUST INFORMATION/ADDITIONAL BENEFICIARY

Please complete the following sections if Ownership and/or Beneficiary is a trust *(or if additional room is needed to list beneficiaries of Policy)*:

1. POLICYOWNER

Name of Trust | Date of Trust *(MM/DD/YYYY)* / /

Name of Trustee(s) | Tax ID No.

Address of Trustee(s) *Street Address* *City* *State* *ZIP+4*

2. BENEFICIARIES

☐ Testamentary Trust *(Will)* Share % _____

☐ Living Trust *(Please complete information below.)* Share % _____

Name of Living Trust | Date of Trust *(MM/DD/YYYY)* / /

Name of Trustee(s) | Tax ID No.

Street Address *City* *State* *ZIP+4*

Address of Trustee(s)

3. ADDITIONAL BENEFICIARIES *(Do not complete if applying for Reversionary Annuity)*

Primary Beneficiary Name *(First, Middle, Last)*	Relationship	Social Security No.	Date of Birth *(MM/DD/YYYY)*	Share %
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

Contingent Beneficiary Name *(First, Middle, Last)*	Relationship	Social Security No.	Date of Birth *(MM/DD/YYYY)*	Share %
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

GENERAL SECTION

Please answer the following questions:

1. Does any Proposed Insured belong to or intend to join the National Guard or military? ☐ Yes ☐ No

2. During the past **5 years** or within the next **12 months**:

   a. Has any Proposed Insured flown other than as a fare-paying passenger, or is any Proposed Insured contemplating flying as a pilot, crew member or student? ☐ Yes ☐ No

   b. Has any Proposed Insured participated in, or contemplated participation in, any hazardous sport or activities? ☐ Yes ☐ No

   If YES, check all that apply:
   ☐ Skin/Scuba Diving ☐ Bungee Jumping ☐ Skydiving/Parachuting/Hang Gliding
   ☐ Motor-powered Racing ☐ Boxing ☐ Rodeo ☐ Professional, Semi-professional or Club Sports
   ☐ Cave Exploration ☐ Mountain/Rock/Ice Climbing ☐ Hot Air Ballooning

3. During the next **12 months**, does any Proposed Insured contemplate residence or travel outside of the United States? ☐ Yes ☐ No

   If YES, please explain _____

4. During the past **12 months**, has any Proposed Insured had a change in weight of more than 10 pounds? ☐ Yes ☐ No

   If YES, please list Proposed Insured's name, amount of weight change and reason for change:

   _____

5. During the past **5 years**, has any Proposed Insured:

   a. Had a life, health or hospital expense insurance application postponed, rated up or declined; had a condition excluded; or had insurance renewal or reinstatement refused? ☐ Yes ☐ No

   If YES, please explain _____

   b. Received benefit payments for accident or sickness, or applied to any government or insurance organization for such benefits? ☐ Yes ☐ No

   If YES, please explain _____

6. Is any Proposed Insured currently negotiating for other insurance coverage? ☐ Yes ☐ No

   If YES, please explain _____

7. During the past **5 years**, has any Proposed Insured:

   a. Had their driver's license suspended or revoked, been convicted of or entered a plea of "guilty" or "no contest" to driving under the influence *(DUI/DWI)*, or had more than 3 moving violations? ☐ Yes ☐ No

   If YES, please explain _____

   b. Been convicted of a felony? ☐ Yes ☐ No

   If YES, please explain _____

8. Is any Proposed Insured currently on probation? ☐ Yes ☐ No

   If YES, please list Proposed Insured's name, reason for probation and length of probationary period:

   _____

9. a. Is other insurance coverage in force for any Proposed Insured? ☐ Yes ☐ No

   If YES, provide details below. If any Proposed Insured is applying for life coverage, complete and return the appropriate State Replacement Form.

   b. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No

   If Yes and applying for health coverage, please complete and return the appropriate State Replacement Form.

Insured's Name	Company Name	Policy No.	Individual (I) Group (G)	Benefits *(monthly benefit and benefit period for DI or face amount for Life)*	Issue Date *(MM/DD/YYYY)*	DI Coverage Only	
						Coordinates w/ Soc. Sec.?	Employer Paid?
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No
			☐ I ☐ G		/ /	☐ Yes ☐ No	☐ Yes ☐ No

10. **If the Proposed Insured is a juvenile,** please list the total amount of life insurance in force and pending on **all** family members. If additional space is needed, attach a separate sheet of paper.

Father	Mother	Sibling 1	Sibling 2	Sibling 3	Sibling 4	Sibling 5
$	$	$	$	$	$	$

PHYSICIAN INFORMATION

Please list the last physician seen:

Name _____ Date last consulted ____/____/____
MM/DD/YYYY

Address _____
Street Address *Suite*

_____
City *State* *ZIP+4*

Phone No. (____) _____ Fax No. (____) _____

Is this your primary physician? ☐ Yes ☐ No

Reason for consultation _____

Results _____

_____

AGREEMENT

I *(We)* have read the above questions and answers and declare that they are complete and true to the best of my *(our)* knowledge and belief. I *(We)* agree that this application shall form a part of the policy if attached thereto.

I *(We)* agree that:

a. In the event the first full premium on the policy applied for is paid upon the date of this application, the insurance under such policy shall take effect as provided in the Temporary Conditional Insurance Agreement delivered by the Company's agent in exchange for such payment.

b. In the event the first full premium on the policy applied for is not paid upon the date of this application, the insurance under such policy shall not take effect unless: a) The application is approved by the Company at its home office, b) Such policy is issued and delivered to the Proposed Insured/ Owner, and c) Such first full premium is paid during the Proposed Insured's lifetime and continued good health and the life and continued good health of any other person(s) covered under the policy. When such approval, issue, delivery and payment have occurred, the insurance under such policy shall take effect as of the date of issue specified in the policy.

c. No agent or medical examiner is authorized or has power to change or waive any term, provision or condition of this application, the Temporary Conditional Insurance Agreement or the policy applied for, or to pass upon or approve insurability of any person for whom insurance is applied for.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

Substitute Form W-9 information *(Request for Taxpayer Identification Number and Certification)*: I, the Owner *(or each Joint Owner)*, certify under penalties of perjury that the number shown is my correct Taxpayer Identification Number. I am not subject to backup withholding due to failure to report interest and dividend income, and I am a U.S. Person *(including a U.S. resident alien)*. The Internal Revenue Service does not require my consent to any provision of this document other than the certification required to avoid backup withholding.

Signed at _____ on ____/____/____
City *State* *Date (MM/DD/YYYY)*

_____ _____
Signature of Proposed Insured *Signature of Additional Proposed Insured*

_____ _____
Signature of Parent/Guardian of Minor Child *Signature of Additional Proposed Insured*

_____ _____
Signature of Owner(s) (If other than Proposed Insured) *Signature of Beneficiary (If applying for Reversionary Annuity)*

_____ _____
Signature of Licensed Agent *Print Agent Name and Agent No.*

FIELD UNDERWRITER'S STATEMENT

1. a. What amount was collected with this application? $ _____

   b. Has a Temporary Conditional Insurance Agreement been given to the Policyowner? ☐ Yes ☐ No

   c. Has the Proposed Insured signed a Confidential Information Authorization and been given a Consumer Notice? ☐ Yes ☐ No

2. a. Did you personally see all Proposed Insured(s) on the date of application? ☐ Yes ☐ No

   b. How well do you know the Proposed Insured(s)? ☐ Well ☐ Slightly ☐ Not at all

   c. Are you aware of anything about the health, habits, hobbies or mode of living which might affect the insurability of the Proposed Insured? If YES, please provide details below. ☐ Yes ☐ No

   _____

3. Is this application being submitted on a non-medical basis? If NO, check items below for which arrangements have been made. ☐ Yes ☐ No

   Agent is responsible for scheduling exam items.

   NOTE: ANY PREFERRED PLANS REQURE AN EXAM, BLOOD SAMPLE (NOT A DRIED BLOOD SPOT) AND URINE SAMPLE.

   ☐ Paramedical examination ☐ Blood Sample ☐ Urine Sample ☐ Electrocardiogram *(EKG)* ☐ Treadmill EKG ☐ Medical exam by physician

4. Is other insurance coverage in force for any Proposed Insured? ☐ Yes ☐ No

5. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No

6. Was sales material used in soliciting this application? ☐ Yes ☐ No

7. Was the sales material left with the applicant? ☐ Yes ☐ No

8. Was the sales material approved by Assurity Life Insurance Company? ☐ Yes ☐ No

9. Are commissions to be split? ☐ Yes ☐ No Agent No. _____ % Agent No. _____ %

AUTOMATIC PAYMENT OPTIONS

☐ Set up NEW bank withdrawal—submit signed authorization and to ensure accuracy, a voided check.

☐ Add to existing bank withdrawal—indicate other applicant and/or policy numbers _____

☐ Set up NEW credit card payment—submit signed authorization with the application.

LIST BILL

☐ Set up NEW list bill— submit signed authorization with the application.

☐ Add to existing list bill; indicate list bill no. _____ and/or name of company _____

FOR TERM LIFE APPLICATION

The premiums for this application were quoted on the following underwriting classification:

$350,000 and under: ☐ Select + NT ☐ Select NT ☐ Standard NT ☐ Select + T ☐ Select T ☐ Standard T

$350,001 and over: ☐ Preferred + NT ☐ Preferred NT ☐ Standard NT ☐ Preferred T ☐ Standard T

Other Insured's underwriting classification _____

FOR WHOLE LIFE APPLICATION ***(either a signed illustration or a signed Illustration Disclosure Statement must be submitted with the application)***

The premiums for this application were quoted on the following underwriting classification:

$99,999 and under: ☐ Select NT ☐ Standard T

$100,000 and over: ☐ Preferred + NT ☐ Preferred NT ☐ Select NT ☐ Preferred T ☐ Standard T

Other Insured's underwriting classification _____

FOR UNIVERSAL LIFE APPLICATION ***(either a signed illustration or a signed Illustration Disclosure Statement must be submitted with the application)***

The premiums for this application were quoted on the following underwriting classification:

☐ Preferred + NT ☐ Preferred NT ☐ Select NT ☐ Preferred T ☐ Standard T

Additional Insured's underwriting classification _____

FOR REVERSIONARY ANNUITY APPLICATION ***(either a signed illustration or a signed Illustration Disclosure Statement must be submitted with the application)***

The premiums for this application were quoted on the following underwriting classification: ☐ Preferred NT ☐ Standard NT ☐ Tobacco

I hereby certify that to the best of my knowledge and belief, the answers on the application and in this statement are true and correct.

_____	/ /	( ) / ( )
Signature of Soliciting Agent	*Date (MM/DD/YYYY)*	*Business Phone No. and Fax No.*
_____	_____	_____
Soliciting Agent's Printed Name	*Agent No.*	*Agent's E-mail*

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GUARANTEED INSURABILITY INSURANCE APPLICATION

PLEASE PRINT WITH BLACK INK

1. INSURED

Legal Name (*First* / *Middle* / *Last*) | Existing Policy No.

Social Security No. | ☐ Male ☐ Female | Date of Birth (*MM/DD/YYYY*) / / | Age

Home Address (*Street Address* / *City* / *State* / *ZIP+4*)

Personal Phone No. ( ) | Birth State/Country | E-mail

2. FINANCIAL INFORMATION

Primary Employer | Employer's Address (*Street Address* / *City* / *State* / *ZIP+4*)

Occupation | Duties

For personal disability income

Gross monthly income $ _____ *(submit two months' pay stubs)*

If self-employed, net monthly income $ _____ *(submit most current tax return, any accompanying schedules and W-2)*

For business overhead expense and mortgage disability income

Current total monthly mortgage/escrow payment $ _____ *(submit most current mortgage billing statement(s))*

Current business expenses $ _____ *(submit current tax return and all schedules filed to reflect current business expenses)*

3. COVERAGE

Note: Any exclusion(s) currently on the existing policy will also be an exclusion for the coverage being applied for.

Additional monthly benefit income amount requested $ _____

1. Is the Insured currently totally or partially disabled? ☐ Yes ☐ No
   If YES, please explain _____
2. Is other disability income insurance coverage in force or pending for the Insured? ☐ Yes ☐ No
   If YES, provide details below.
3. If this insurance is issued, will it replace, modify or borrow against existing or pending coverage? ☐ Yes ☐ No
   If YES, please complete and return the appropriate State Replacement Form if applicable.

Company Name	Policy No.	Business *(B)* Personal *(P)*	Monthly Benefit and Benefit Period	Issue Date *(MM/DD/YYYY)*	Coordinates w/ Soc. Sec.?	Employer Paid?
		☐ B ☐ P		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		☐ B ☐ P		/ /	☐ Yes ☐ No	☐ Yes ☐ No
		☐ B ☐ P		/ /	☐ Yes ☐ No	☐ Yes ☐ No

AGREEMENT

I have read the above questions and answers and declare that they are complete and true to the best of my knowledge and belief. I agree that this application shall form a part of the policy if attached thereto.

I hereby acknowledge that I have read and understand the applicable state fraud information given below.

Signed at _____ on _____ / _____ / _____
City *State* *Date (MM/DD/YYYY)*

_____ _____
Signature of Insured *Signature of Agent*

FRAUD NOTICES

Unless specific state language is provided below for your state of residence, the following general fraud notice applies.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

[**DC RESIDENTS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FL RESIDENTS: Any person who knowingly, and with intent to injure, defraud or deceive any insurance company, files a statement of claim or an application containing any false, incomplete or misleading information, is guilty of a felony in the third degree.

KS RESIDENTS: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime as determined by a court of law and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

KY RESIDENTS: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may also be subject to a substantial civil penalty where and to the extent allowed by state law.

LA RESIDENTS: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to fines and confinement in prison.

OK RESIDENTS: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive an insurer, makes any claim for the proceeds of any insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OR RESIDENTS: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, and may be subject to a substantial civil penalty where and to the extent allowed by state law.

PA RESIDENTS: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TN, VA, WA RESIDENTS: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

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Temporary Conditional Insurance Agreement

(for use with all Health products)

Proposed Insured No. 1 _____ Date Application Signed ___/___/___

Proposed Insured No. 2 _____ Date Application Signed ___/___/___

In consideration of the premium received with the health insurance application listed above *(Application)*, Assurity Life Insurance Company *(Assurity)* will provide temporary health insurance coverage subject to the terms and conditions contained in this Agreement. Make all checks payable to Assurity. Do not make checks payable to the agent. Do not leave the check payee blank.

If questions 3 a-d are answered YES or are left BLANK, there will be NO CONDITIONAL COVERAGE
The agent is not authorized to accept a premium under these circumstances.

1. Is any Proposed Insured younger than 15 days old or older than 75 years old? ☐ Yes ☐ No
2. Does the Proposed Insured:
   a. Have Assurity policies for disability income or business overhead expense that, combined with the applied for coverage, exceeds $4,000 per month? ☐ Yes ☐ No
   b. Have Assurity hospital indemnity or Assurity critical illness coverage? ☐ Yes ☐ No
3. Has any Proposed Insured:
   a. **Ever** had a heart, lung, liver or kidney disease or disorder; diabetes; stroke; paralysis or cancer? ☐ Yes ☐ No
   b. **Ever** been diagnosed or treated by a medical professional for acquired immune deficiency syndrome *(AIDS)* or AIDS-related complex *(ARC)*? ☐ Yes ☐ No
   c. During the past **5 years** been treated, counseled or advised to seek treatment for drug/alcohol abuse? ☐ Yes ☐ No
   d. During the past **90 days** been admitted, or advised by a medical profession to be admitted to a hospital or other licensed health care facility; had surgery or had surgery recommended by a medical professional; or been advised by a medical professional to have any diagnostic test that was not completed *(excluding an AIDS-related test)*? ☐ Yes ☐ No

No coverage starts:

- Until the later of **1)** the date the Proposed Insured completed and signed the Application and paid the first full modal premium *(a check is not payment unless honored by the issuing institution when first presented)*; or **2)** the date the Proposed Insured completed all medical tests required by Assurity **and**
- Unless the Proposed Insured is insurable on the date coverage starts at Assurity's **standard or better than average rates** *(no ratings included)*, according to its underwriting practices for the amount of insurance and any additional benefits applied for.

If the Proposed Insured is diagnosed by a medical professional with a covered medical condition, Assurity shall not be liable for**:**

- More than $2,500 of disability coverage or business overhead coverage; or
- More than the applied for amount of hospital indemnity; or
- More than $50,000 of critical illness coverage. This includes any other critical illness coverage applied for with Assurity.

If no Policy is issued and delivered and no benefit is paid under this Agreement, all premiums paid will be returned. If the Policy is issued as applied for, or if a Policy amendment is accepted by the Proposed Owner, premium paid will be applied to that Policy. No change in health will be used to deny a Policy if the change occurs after the later of: **1)** the date of the Application; or **2)** completion of all medical tests required by Assurity.

Coverage under this Agreement terminates automatically on the earliest of the date:

- 90 days from the date of the Application;
- Premium is returned by Assurity *(return is effective on being postmarked, properly addressed and postage prepaid)*;
- Coverage starts under any Policy resulting from the Application; or
- A Policy resulting from the Application is refused by the Proposed Owner.

The undersigned states that the answers on this Agreement and the Application are true and complete to the best of his/her knowledge and belief, and understands that the answers are relied upon for coverage under this Agreement. Assurity's liability will be limited to a return of the premium submitted if: **1)** the Proposed Insured dies by suicide; or **2)** the Application or this Agreement contains a material misrepresentation to Assurity.

Dated at _____ On _____
City, State *Date (MM/DD/YYYY)*

_____ _____
Signature of Proposed Insured No. 1 *Signature of Proposed Insured No. 2*

_____ _____
Signature of Agent or Witness (disinterested person) *Print Agent or Witness Name*

_____
Signature of Owner (if other than Proposed Insured)

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TOBACCO USE QUESTIONNAIRE

Insured's Name _____ Policy No. _____
First *Middle* *Last*

During the past 12 months, have you smoked cigarettes? ..... ☐ Yes ☐ No

During the past 12 months, have you used any form of tobacco, nicotine-based products or substitutes such as patches or gum? ..... ☐ Yes ☐ No

If YES, please list type(s) _____

If you have quit smoking or quit using tobacco in any form, please provide the date you quit ____/____/____ *(MM/DD/YYYY)*

I have read the above questions and declare that the answers are complete and true to the best of my knowledge and belief.

____/____/____ _____
Date (MM/DD/YYYY) *Signature of Insured*

SERFF Tracking Number:	*SEFL-126646812*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46120*
Company Tracking Number:	*IND APPS 2010 - HEALTH*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*IND APPS 2010 - Health*		
Project Name/Number:	*IND APPS 2010 - Health/IND APPS 2010 - Health*		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	07/08/2010
Comments:			
Attachment:			
READ CERT-H.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	07/08/2010
Bypass Reason:	N/A Application filing		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	07/08/2010
Bypass Reason:	N/A Application filing		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	07/08/2010
Bypass Reason:	N/A Application filing		
Comments:			

READABILITY CERTIFICATION

I hereby certify the following forms were tested for readability using Microsoft® Word XP program and achieved the following test results:

Company Name: Assurity Life Insurance Company

Form Number(s):

Type of Form: Health Application

Form No.	Description	Flesch Score
47-350-05051 (R05-10)	Application for Insurance	55.6
47-351-05051 (R05-10)	Trust Information/Additional Beneficiary	64.4
47-352-05051 (R05-10)	General Section	50.0
47-354-05051 (R05-10)	Physician Information and Agreement	50.3
47-362-05051 (R05-10)	Field Underwriter's Statement	57.3
75-315-02201	Guaranteed Insurability Insurance Application	46.5
75-803-02255	Temporary Conditional Insurance Agreement	50.8
75-819-05055	Tobacco Use Questionnaire	65.9

Carol S Watson
Signature

June 29, 2010
Date

Carol S. Watson
Vice President, General Counsel and Secretary

SERFF Tracking Number:	*SEFL-126646812*	*State:*	*Arkansas*
Filing Company:	*Assurity Life Insurance Company*	*State Tracking Number:*	*46120*
Company Tracking Number:	*IND APPS 2010 - HEALTH*		
TOI:	*H21 Health - Other*	*Sub-TOI:*	*H21.000 Health - Other*
Product Name:	*IND APPS 2010 - Health*		
Project Name/Number:	*IND APPS 2010 - Health/IND APPS 2010 - Health*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
05/27/2010	Form	Temporary Conditional Insurance Agreement	07/02/2010	75-803-02255 Health 05-10.pdf